DWS-SDS
Form 760, 03/03

Department of Workforce Services & Department of Health

24 30 53

REQUEST FOR SOCIAL SECURITY INFORMATION & INFORMATION EXCHANGE

The individual named below is applying for benefits from Utah Department of Workforce Services and/or Department of Health. To establish/continue his or her eligibility, verification of Social Security benefits is needed. Please verify status of benefits below. ***Be sure to address all boxes that are checked.***

	Date:	
	Fax #:	
	Signature:	
	Title:	
Requesting Agency	Phone #:	

VERIFY STATUS OF CURRENT BENEFITS INDICATED BELOW

Client Name: _____ SSN: _____

- ☐ Date applied for benefits: _____ ☐ Appeal pending? ☐ Yes ☐ No
- ☐ Date benefits approved: _____ ☐ Benefits pending? ☐ Yes ☐ No
- ☐ Date denied benefits: _____
- ☐ Dual benefits? ☐ Yes ☐ No If yes, please list: _____
- ☐ Name and date of birth as it appears on your records: _____

- ☐ **Current Total Monthly Benefit:** _____ **Correct Information**
- ☐ Monthly SSA (Title II) Payment: _____
- ☐ Type of Entitlement: _____
- ☐ Monthly SSI Payment: _____
- ☐ **Medicare Information:** _____
- ☐ Medicare Eligibility: ☐ Part A ☐ Part B Start Date: _____
- ☐ Overpayment amount withheld: $ _____ Start Date: _____ End Date: _____
- ☐ Other withholding amount: $ _____ Start Date: _____ End Date: _____

- ☐ **Lump Sum**: Initial lump sum amount: $ _____ Date Received: _____
- ☐ Are there additional lump sums expected? ☐ Yes ☐ No If yes, when? _____
- ☐ **Death Notification**: Date of Death: _____
- ☐ **Nursing Home Entry**: Date Entered: Release Date:
- ☐ Length of stay: ☐ Short (6 months or less) ☐ Long (6 months or more)
- ☐ Date SSI decreased to $30: _____ Date SSI reinstated: _____
- ☐ Enroll Individual in Part B Medicare (SMI): Name: _____
- ☐ Social Security Claim #: _____ Date of Birth: _____
- ☐ Social Security Number Holder's Name (if different): _____
- ☐ Comments: _____

_____

_____

Signature Date Phone # Fax #